

**ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES**

**Community Service Agency Title XIX Certification
APPLICATION**

Provider Information	
<p>(1) Type of Application: check one <input type="checkbox"/> Initial <input type="checkbox"/> Amendment <i>Applicants must submit an application for each provider facility</i> <input type="checkbox"/> Renewal</p>	
<p>(2) Reason for Amendment Request: <input type="checkbox"/> tax ID change <input type="checkbox"/> addition of a Tier II service/specify: _____ <input type="checkbox"/> telephone number change <input type="checkbox"/> name change _____ <input type="checkbox"/> address change <input type="checkbox"/> change in program director <input type="checkbox"/> addition/removal of a T/RBHA affiliation <input type="checkbox"/> change in ownership <input type="checkbox"/> AHCCCS provider type change/specify date: from _____ to _____</p>	
<p>(3) Date of Application: _____/_____/_____ (4) AHCCCS Provider ID #: _____</p>	
<p>(5) Provider Name: _____</p>	<p>(6) Provider Phone Number: () _____ - _____</p>
	<p>(7) Provider E-Mail Address: _____</p>
<p>(8) Provider Facility Address: _____ City: _____ State: _____ Street _____ Zip: _____ County: _____</p>	
<p>(9) Provider Mailing Address: _____ City: _____ State: _____ Street _____ Zip: _____ County: _____</p>	
<p>(10) Program Director's: Name: _____ Credentials: _____ Phone Number: _____</p>	<p>(11) RBHA(s) or Tribal RBHA(s) with which <input type="checkbox"/> Applicant contracts or <input type="checkbox"/> Intends to contract: Check all that apply <input type="checkbox"/> CPSA-3 <input type="checkbox"/> PGBHA <input type="checkbox"/> CPSA-5 <input type="checkbox"/> NARBHA <input type="checkbox"/> EXCEL <input type="checkbox"/> Value Options <input type="checkbox"/> Navajo <input type="checkbox"/> Gila River <input type="checkbox"/> Pasqua Yaqui</p>
<p>(12) Tax ID#: _____ <u>OR</u> Social Security Number: _____</p>	
Provider Enclosures	
<p>(13) Enclose the following with this application: (please check the box beside each document enclosed) <input type="checkbox"/> copy of provider incorporation documents <input type="checkbox"/> copy of provider charter, if any <input type="checkbox"/> copy of Occupancy Permit for provider facility address <input type="checkbox"/> copy of current passing fire inspection Fire inspection required every two years for renewal certification</p>	
Services Provided	
<p>(14) Check all services below that your agency provides for which you request Title XIX Certification: Please indicate in a cover letter which services you wish to add or delete when requesting renewal or amended certifications <input type="checkbox"/> Unskilled Respite S5150, S5151 <input type="checkbox"/> Self-help Peer Service H0038, H0038HQ or Comprehensive Community Support Services H2016 <input type="checkbox"/> Support to Maintain Employment H2025, H2026 <input type="checkbox"/> Supervised Day H2012 or Comprehensive Community Support H2015 <input type="checkbox"/> Personal Care T1019 or T1020 <input type="checkbox"/> Home Care Training Family S5110 <input type="checkbox"/> Psychoeducational Service H2027 <input type="checkbox"/> Skills Training H2014, H2014HQ or Psychosocial Rehabilitation H2017 <input type="checkbox"/> BH Prevention/Promotion Education H0025</p>	

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(15) Name of Staff Member, Volunteer or Contractor	Unskilled Respite	Personal Care	Skills training or Psycho- social Rehabilitation	Self-help Peer Service or Comprehensive Community Support Services	Home Care Training Family	BH Prevention / Promotion Education	Support to Maintain Employ- ment	Psycho- educational service	Supervised Day or Comprehensive Community Support

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Direct Service Staff or Contractor Enclosures

Complete pages 3 – 5 for each direct service staff member, volunteer, or contractor – attach all items to this form

(16) **Name of direct service staff, volunteer, or contractor:** _____
Name of provider: _____

Tier I (17) and (18)

Attach each item to this form:

- ☐ credible proof of age 18 or older
- ☐ three letters of reference

Tier I

(17) If direct service staff or contractor provides:
(check all that apply)

- ☐ Unskilled Respite
- ☐ Personal Care
- ☐ Self-help Peer Service /Comprehensive Community Support Services

☐ Providing transportation services to clients? ☐ Yes ☐ No
If Yes, then attach the following to this form:

- ☐ copy of current driver's license
- ☐ copy of current vehicle registration (for vehicle used to transport clients)
- ☐ copy of current liability insurance as required by A.R.S. 28-4009 (for vehicle used to transport clients)

Attach to this form

- ☐ credible evidence of one of the following credentials as defined in ADHS/DBHS Policy MI 5.2 Community Service Agencies – Title XIX Certification
 - ☐ Behavioral Health Professional
 - ☐ Behavioral Health Technician
 - ☐ Behavioral Health Paraprofessional

Tier I (cont.)

(18) If direct service staff or contractor provides:
(check all that apply)

- ☐ Ongoing support to Maintain Employment
- ☐ Psychoeducational Service

Attach to this form

- ☐ credible evidence of one of the following credentials as defined in ADHS/DBHS Policy MI 5.2 Community Service Agencies – Title XIX Certification
 - ☐ Behavioral Health Technician
 - ☐ Behavioral Health Paraprofessional

Attach to this form

- ☐ credible evidence of one year work experience in providing rehabilitation services to people with disabilities

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<p>(19) Name of direct service staff or contractor: _____</p> <p> Name of provider: _____</p>	
<p>Tier II (20) – (24)</p>	<p>Attach each item with this form</p> <p><input type="checkbox"/> credible proof of age 21 or older</p> <p><input type="checkbox"/> three letters of reference</p>
<p>Tier II</p> <p>(20) If direct service staff or contractor provides:</p> <p><input type="checkbox"/> BH Prevention/Promotion Education</p> <p><input type="checkbox"/> Skills Training</p> <p><input type="checkbox"/> Home Care Training Family</p> <p><input type="checkbox"/> Supervised Day or Comprehensive Community Support</p>	<p><input type="checkbox"/> Providing transportation services to clients? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, then attach the following to this form:</p> <p><input type="checkbox"/> copy of current driver's license</p> <p><input type="checkbox"/> copy of current vehicle registration (<u>for vehicle used to transport clients</u>)</p> <p><input type="checkbox"/> copy of current liability insurance as required by A.R.S. 28-4009 (<u>for vehicle used to transport clients</u>)</p>
<p>Tier II (cont.)</p> <p>(21) If direct service staff or contractor provides:</p> <p><input type="checkbox"/> Home Care Training Family</p> <p><input type="checkbox"/> Skills Training</p> <p><input type="checkbox"/> Supervised Day or Comprehensive Community Support</p>	<p>Attach to this form</p> <p><input type="checkbox"/> credible evidence of one of the following credentials as defined in ADHS/DBHS Policy MI 5.2 Community Service Agencies - Title XIX Certification</p> <p><input type="checkbox"/> Behavioral Health Professional</p> <p><input type="checkbox"/> Behavioral Health Technician</p> <p><input type="checkbox"/> Behavioral Health Paraprofessional</p>
<p>Tier II (cont.)</p> <p>(22) If direct service staff or contractor provides</p> <p><input type="checkbox"/> BH Prevention/Promotion Education services</p>	<p>Attach to this form</p> <p><input type="checkbox"/> Credible evidence of one of the following credentials as defined in ADHS/DBHS Policy MI 5.2 Community Service Agencies - Title XIX Certification</p> <p><input type="checkbox"/> Behavioral Health Professional</p> <p><input type="checkbox"/> Behavioral Health Technician</p>
<p>(23) <input type="checkbox"/> If providing services to persons less than 18 years of age</p>	<p>Attach to this form</p> <p><input type="checkbox"/> Copy of Class One or Class Two Fingerprint Clearance Card</p> <p>or</p> <p><input type="checkbox"/> Copy of DPS Form 802-06857 Applicant Fingerprint Clearance Card Application dated within 7 days of the direct service staff or contractor's date of hire</p> <p>and</p> <p><input type="checkbox"/> Copy of the completed and notarized State of Arizona Criminal History Affidavit form</p>
<p>(24) <input type="checkbox"/> If providing services to persons 18 years and older</p>	<p>Attach to this form</p> <p><input type="checkbox"/> Copy of completed and notarized ADHS/DBHS Self-Declaration of Criminal History form</p>

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Attach to this form

(25) For all direct service staff or contractors providing rehabilitative and support services as defined in ADHS/DBHS Policy MI 5.2 Community Service Agency - Title XIX Certification:

- ☐ Copy of current Cardiopulmonary Resuscitation Certificate ☐ Copy of current First Aid training verification
- ☐ Credible evidence of current freedom from infectious pulmonary tuberculosis

Attach to this form

(26) ☐ Credible evidence of the following required training **prior to the provision of direct services to clients:**

Training Content	Date of Completion	Training Content	Date of Completion
<input type="checkbox"/> client rights	____/____/____	<input type="checkbox"/> record keeping and documentation	____/____/____
<input type="checkbox"/> promoting client dignity, independence, individuality, strengths, privacy and choice	____/____/____	<input type="checkbox"/> ethical behavior	____/____/____
<input type="checkbox"/> Recognizing common symptoms of and differences between a mental disorder, personality disorder, and/or substance abuse	____/____/____	<input type="checkbox"/> recognizing and responding to a client who may be a danger to self or others, behave in an aggressive manner, need crisis services, or be experiencing a medical emergency	____/____/____
<input type="checkbox"/> client record and information confidentiality	____/____/____		

Signatory Information

By signing below, I affirm under penalty of law that the information provided on this form is true, accurate, and complete to the best of my knowledge.

Signature of Provider Director/Title

Date

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Community Service Agency Title XIX Certification Application Instructions

A. Initial Application

1. Check the "Initial" box in *section (1) Type of Application* on page one of the application form.
2. Complete all sections of the application form and enclose all required forms, certifications, permits, inspections, and documents with the application form.
3. The provider Director signs and dates the application form and indicates his/her title on the form.
4. The completed application is mailed or hand delivered to the RBHA or Tribal RBHA with which the provider plans to contract.

Community Partnership of Southern Arizona	4575 East Broadway Boulevard Tucson, Arizona 85711
The EXCEL Group	2573 Arizona Avenue, Suite 1 Yuma, Arizona 85364
Northern Arizona Regional Behavioral Health Authority	1300 S. Yale Street Flagstaff, Arizona 86001
Pinal Gila Regional Behavioral Health Association, Inc.	2066 West Apache Junction Trail, Suite 116 Apache Junction, Arizona 85220
Value Options	Four Gateway Plaza 444 N. 44 th Street, Suite 400 Attention: Network Management Department Phoenix, Arizona 85008
Gila River	Department of Health Services Behavioral Health Care Clinic/RBHA P.O. Box 38 Sacaton, Arizona 85247
Navajo Nation	The Navajo Nation P.O. Drawer 709 Window Rock, Arizona 86515
Pasqua Yaqui	Pasqua Yaqui RBHA 7474 South Camino DeOeste Tucson, Arizona 85746

5. The RBHA or Tribal RBHA reviews the proposed provider's application for completeness. Once it is determined that the application is complete, the RBHA or Tribal RBHA forwards the completed application packet to:

Arizona Department of Health Services
Division of Behavioral Health Services
Attention: Office for Contract Compliance
150 N. 18th Avenue, Suite 260
Phoenix, Arizona 85007

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B. Application for Renewal

1. Check the “Renewal” box in *section (1) Type of Application* on page one of the application form.
2. Complete sections (2) through (12) of the application.
3. Enclose a copy of the current passing fire inspection referenced in section (13) every two years from the initial application date. Enclose a copy of the current health and safety inspection. Enclose a copy of the Occupancy permit if changed.
4. Complete section (14) indicating the services provided for which Title XIX Certification is requested.
5. Complete sections (15) through (26) of the application for all direct service staff, volunteers, or contractors.
6. Complete section (26) for direct service staff members, volunteers, or contractors hired subsequent to the initial certification date and before the renewal application date or between renewal certification dates and who are providing services at the date of the renewal application.
7. Enclose all required forms, certifications, permits, inspections, and documents with the application form.
8. The provider Director signs and dates the application form and indicates his/her title on the form.
9. The completed application is mailed or hand delivered to the RBHA or Tribal RBHA with which the provider contracts or intends to contract.
10. The RBHA or Tribal RBHA reviews the proposed provider’s application for completeness. Once it is determined that the application is complete, the RBHA or Tribal RBHA forwards the completed application packet to ADHS/DBHS at the address listed in 1.e. above.

C. Application for Amendment

1. Check the “Amendment” box in *section (1) Type of Application* on page one of the application form.
2. Complete sections (2) through (14) of the application.
3. If adding a new service, complete sections (15) through (26) of the application for all direct service staff, volunteers, or contractors.
4. Enclose all required forms, certifications, permits, inspections, and documents with the application form.

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5. The provider Director signs and dates the application form and indicates his/her title on the form.
6. The completed application is mailed or hand delivered to the RBHA or Tribal RBHA with which the provider plans to contract.
7. The RBHA or Tribal RBHA reviews the proposed provider's application for completeness. Once it is determined that the application is complete, the RBHA or Tribal RBHA forwards the completed application packet to ADHS/DBHS at the address listed in A.5. above.